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LINKING ALCOHOL SERVICES RESEARCH AND PRACTICE

Editor's Note

The number and magnitude of disparities related to the treatment of alcohol-related problems underscore how much needs to be done to improve access to alcohol treatment in this country. This issue of *FrontLines* explores some of the many facets concerning disparities in alcohol treatment.

In the Invited Commentary, Isaac Montoya of Affiliated Systems provides an overview of alcohol-related disparities and a discussion of NIAAA's new strategic plan for addressing disparities. Jean-Marie Mayas, president of the MayaTech Corp., offers a response in which he calls on not only the treatment community but also the alcohol industry to look inward so that disparities can be eliminated.

A series of Research Highlight articles sheds further light on these issues. Henrick Harwood and his colleagues at the Lewin Group report on findings from their analysis of demographic and socio-economic data. Thomas Greenfield of the Alcohol Research Group discusses problems among specific population groups with prevalence as well as access to treatment.

Research by Jennifer Mertens, Constance Weisner, and Stacy Sterling on disparities across treatment settings carries particularly important implications for screening and diagnosis.

Finally, Scott Tonigan of the University of New Mexico at Albuquerque reports on disparities among Hispanics and non-Hispanic whites.

We hope that you find this issue of *FrontLines* interesting and informative.

COMMENTARY

Untangling the Web: Disparities in Alcohol Abuse and Alcoholism

By Isaac D. Montoya, Ph.D., CMC, CLS, Affiliated Systems Corporation

Health-related disparities are significant differences in the incidence, prevalence, morbidity, mortality, and burden of diseases among specific population groups. As research continues to demonstrate glaring disparities for a wide range of health problems and groups, it is more important than ever that we improve our understanding of what causes health disparities and work to address them. That's as true for the alcohol research and treatment community as it is for the general health care community.

We know, for example, that alcohol-related death rates are highest among African Americans, even though a larger proportion of African Americans compared to whites abstain from alcohol. In 1996, the death rate attributed to alcohol-related cirrhosis among African American males was 60 percent greater than that among white males. Fetal Alcohol Syndrome (FAS), a preventable condition, is six times more prevalent among African Americans than whites. In certain Native American tribes, the incidence of FAS is 33 times the incidence among whites. The alcohol-related death rate among Native Americans is 5.6 times higher than that of the general population, with the peak ages for death between 45 and 64. Alcohol-related death rates for white Hispanic men are double those for white non-Hispanic men.

Disparities are also apparent in access to alcohol treatment. For example, minority patients are likely to have health insurance that covers alcohol treatment, even though success rates for minority patients who enter treatment programs are unequal to those of whites in the same programs.

Recognizing the striking disparities in illness burden and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, Asians, and Pacific Islanders, the National Institutes of Health (NIH) has developed a five-year *Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities*. Each NIH Institute — including the National Institute on Alcohol Abuse and Alcoholism (NIAAA) — has produced its own mission-specific plan as well, setting forth in greater detail ongoing and planned

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efforts to reduce health disparities among these populations.

The NIAAA plan outlines a series of goals and actions designed to expand understanding of the biological, cultural, environmental, and ethnic factors that contribute to differences in alcohol-related problems. Greater understanding, it is hoped, will lead to more effective prevention and treatment methods for ending those disparities. The plan describes three broad areas of activity:

- Improve scientific knowledge by supporting initiatives to close the gap between what is known and what is suspected about health disparities related to alcohol use, abuse, and dependence — focusing on concerns such as FAS, the toxic effects of alcohol, the impact of genetics, treatment, and prevention.
- Strengthen the research infrastructure on minority health needs by expanding the research capacity of minority-serving institutions and advancing the career development of minority investigators and clinicians.
- Educate and inform minority populations through strategies that include increasing public awareness, engaging health care professionals, and expanding efforts in science education.

The NIAAA plan recognizes that a number of factors — including physiology, psychological experiences, socioeconomic status, and the environment — combine and interact in complex manners to contribute to health disparities. Goals outlined in the plan acknowledge the influence of a wide range of variables such as genetic-based risks, access to care, insurance coverage, social and cultural factors, geographic location, and HIV/AIDS risks on disparities in alcohol-related problems among minority populations.

Taking a Broad View of Disparities

Thus, health disparities need to be viewed as a complex mosaic of interrelated issues and problems. To address these disparities, researchers and clinicians must advance understanding not only of each piece of this puzzle but also how all the pieces fit together and interact to affect health disparities. As a society, we have benefited from coordinated interdisciplinary research efforts designed to enhance understanding of "the big picture." For example, NIH programs in interdisciplinary research and research to practice have made headway in developing effective treatment protocols for many diseases.

The NIAAA plan recognizes that a number of factors — including physiology, psychological experiences, socio-economic status, and the environment — combine and interact in complex manners to contribute to health disparities.

There is a tendency to discuss health disparities solely in terms of differences among racial and ethnic groups. The NIAAA plan acknowledges that multiple factors contribute to this problem, but it is necessary to take an even broader view of health disparities. Differences in education, income, values and beliefs, access to treatment, and religious affiliation are but a few of the variables that may affect health disparities — and they may act to affect the health of any one person differently.

Untangling the web of variables that influence alcohol-related problems presents unique challenges. In our society, alcohol purchase and consumption are legal activities, but alcohol abusers are frequently viewed as immoral or weak-willed individuals who engage in destructive behavior that threatens their families and society. Despite the fact that we know unequivocally that addiction is a disease like any other medical condition, it remains stigmatized. This stigma spills over to many aspects of alcohol research, prevention, and treatment.

As the articles in this issue of *FrontLines* demonstrate, disparities in alcohol-related problems are evident not only along lines of race and ethnicity, but also along lines of age, insurance status, income, and provider setting, among others. These findings illustrate the need to understand alcohol-related disparities from many perspectives. There may be even more factors that we have yet to identify.

The NIAAA strategic research plan offers a good start for expanding our understanding of disparities in alcohol abuse and alcoholism. It lays the foundation for a research program and infrastructure that ultimately will allow us to see the big picture, to identify the pieces of this huge and complicated mosaic and figure out how they fit together. NIAAA's plan presents an opportunity to develop new or improved methods for conducting research studies, engaging people from underserved and vulnerable populations in research, and — hopefully — coming up with the answers we need to eliminate health disparities as we know them. Convenience samples will not provide the level of understanding needed to address health disparities, and innovation is critical to the success of eradicating alcohol-related health disparities.

NIAAA and NIH are taking important and necessary steps to begin to address the difficult issues of health disparities. Strategic plans are in place to guide efforts from investigators. It is now up to the scientific community to respond to this initiative through the demonstration of research studies that further our understanding of the problem and lead to the development of successful interventions and treatment for all members of society.

Information

To obtain the NIH and NIAAA disparities plans on the Internet, go to www.nih.gov/about/hd/strategic-plan.pdf and www.niaaa.nih.gov/about/ Disparitiesintro.htm .

Dr. Montoya is President of Affiliated Systems Corporation, Houston, TX. He is also a professor at the College of Pharmacy at the University of Houston, a member of the NIH Council of Public Representatives, and chair of the NIH Working Group on Health Disparities.

Closing Disparity Gaps Requires Self-Examination by Alcohol Industry

By Jean-Marie Mayas, Ph.D., The MayaTech Corporation

NIAAA's *Strategic Plan to Address Health Disparities* over the next 25 years is broad in its vision and ambitious in its scope. It succeeds in providing strategic foci to the Institute and its research collaborators on key knowledge gaps confronting the field. The challenge now is for NIAAA to operationalize the *Plan's* strategic goals and objectives into specific work plans, and to secure necessary implementing appropriations.

For the most part, however, the *Plan* looks outward to client characteristics (e.g., behavior, culture, comorbidities) and structural obstacles (e.g., insurance coverage) in framing its questions. I believe that we also need to address questions that guide an inward look at the alcohol abuse and alcoholism *industry* as a whole. Examining prevention or treatment alone excludes consideration of potent economic and political factors that influence the scope and character of health disparities. We need to explore a broad range of questions on how our existing systems of thinking and acting contribute to disparity enlargement or reduction. In essence, if all barriers to access were lifted and waiting lists for treatment were eliminated, would disparities evaporate in short order?

While the public policy objective of disparity elimination is clear, how willing are alcohol beverage producers, manufacturers, and distributors to participate in this initiative? How prepared are clinical treatment managers to acquire the cultural competencies that may be needed of them and their staffs? Is there a relationship between racial and ethnic diversity in the industry's work force at all levels and the health disparities of concern?

The Institute's focus on the science of prevention and treatment is appropriate for its mission. However, this knowledge acquisition must recognize and appreciate the need to move more than just the scientific community. The "business" of alcohol abuse and alcoholism prevention and treatment must be challenged to understand its contributions to present-day disparities, and then engaged in the plan to ameliorate them.

As NIAAA's *Plan* is advanced to produce a wealth of new and important information on access, genetics, prevention, and treatment, we should also look within to issues of industry capacity, readiness, self-interest, and will. Closing disparity gaps effectively will require both perspectives.

Health Disparities in Alcohol-Related Disorders, Problems, and Treatment Use By Minorities

By Thomas K. Greenfield, Ph.D., Alcohol Research Group

From the standpoint of alcohol treatment, the health care system in recent years has been undergoing what one recent review termed "chaotic" changes. Pathways to treatment for persons with alcohol problems increasingly depend on organizational and structural factors such as involvement with the criminal justice or welfare systems, or insurance coverage and employer contracts with behavioral health firms.

The expanding role played by structural features of the environment does not diminish the important influence of personal resources. Social networks, pressures from family members and the workplace, and one's own readiness and choices are key factors in the decision to enter treatment. Collectively, these elements generate entitlements, incentives, or coercive fields that move people into treatment — or erect barriers to specific types of people reaching treatment.

To better understand these treatment barriers, there is a critical need to address health disparities and increase knowledge about access to alcoholism treatment services, particularly for minority populations. From a health disparities framework, the basic questions are (1) whether prevalence and severity of alcohol dependence and abuse differ by major demographic grouping such as ethnicity and gender, and (2) given the levels of need, whether access to care is at an equal level.

The broadest answer to the first question is that they do differ, though the data call for closer examination by researchers. While the broadest answer to the second question is no, there are some signs of positive convergence. For example, in the case of gender, signs over the last two decades suggest that women are gaining better access to alcohol treatment.

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Data Analysis Identifies Major Disparities in Alcohol Treatment Access Across Various Groups

By Henrick Harwood, Kate Sullivan, and Deepti Malhotra, The Lewin Group

Access to alcohol treatment in this country is both poor and highly variable. Of an estimated 15 million to 20 million Americans in need of some level of alcohol treatment, it appears that no more than 2 million to 3 million actually get such treatment in a given year. This means that approximately 80 percent of people in need of treatment for an alcohol-related problem go without it. Within this context of huge unmet treatment need, we have identified major differences in access to alcohol treatment across demographic and socio-economic groups.

Using data from the 1995-1997 editions of the National Household Survey on Drug Abuse (NHSDA), we examined treatment access among various demographic and socio-economic segments. We focused on that proportion of the U.S. population ages 12 and older who met DSM-IV criteria for alcohol dependence or who actually got alcohol treatment (self-help group participation is not included in our definition). Our estimate — approximately 4.9 percent of the overall population, or 10.5 million people — is conservative, as it excludes a substantial number of alcohol abusers. We found that only 1.2 percent of the U.S. population — or 2.56 million people — got clinical treatment each year during 1995-1997. Thus, (according to our conservative definition of need), less than 25 percent of people in need of alcohol treatment got it in a given year.

Access by Demographic Characteristics

Socio-Demographic Group	Access Rates
Age	
12-17	0.22
18-25	0.16
26-34	0.30
35-49	0.30
50-64	0.24
65+	0.15
Racial/Ethnic	
White, non-Hispanic	0.25
Black, non-Hispanic	0.23
Hispanic	0.18
Other	0.30

Source: Analysis of the pooled 1995-1997 annual editions of the National Household Survey on Drug Abuse by The Lewin Group.

Disparities Reflect Multiple Treatment Barriers

Age is a significant marker of disparity in access to alcohol treatment. Older drinkers (over 65) appear to have the poorest access — about half the rate of those age 26 to 49 (15 versus 30 percent). While there are only slight differences between males and females, Hispanics at about 18 percent are substantially lower than non-Hispanic whites and blacks, who are relatively similar (25 and 23 percent, respectively). Access in the Northeast (at 33 percent) is better than in the South (19 percent), while the West and North Central regions are at the national average (25 percent). Married drinkers have lower access than divorced drinkers (21 versus 29 percent). Drinkers with less than a high school education have the best access (30 percent), while college-educated individuals who need care are about half as likely to access treatment (17 percent).

Keep in mind that our definition of access — the proportion of those in need of alcohol treatment versus the proportion of those who actually got it — already adjusts for the fact that some populations have different rates of treatment need. For example, at 3.3 percent, the college-educated population has a low rate of treatment need. Nevertheless, the level of unmet treatment need is high, because less than 1 percent of that population obtained treatment.

Disparities in access are strongly related to socio-economic characteristics — and not necessarily in the direction expected. Full-time workers in need of treatment obtain it at less than half the rate of unemployed individuals with treatment need (18 versus 40 percent). Family income is also strongly related to access rate: Drinkers in low-income families (less than $20,000 a year) are twice as likely to get needed alcohol treatment than those in families with income over $75,000 per year (37 versus 18 percent). These results are underscored in data showing that dependent drinkers receiving welfare were about 60 percent more likely to get care than others. Similarly, problem drinkers with coverage from Medicaid or Medicare (and who were disabled and under 65) were more than twice as likely to get treatment as drinkers with private insurance.

Access by Socio-Economic Characteristics

Source of Health Insurance	Access
Medicaid	0.44
Medicare < 65 years	0.49
Medicare 65+ years	0.15
Private, Individual	0.16
Private, Group	0.19
CHAMPUS	0.27
Uninsured	0.28

Source: Analysis of the pooled 1995-1997 annual editions of the National Household Survey on Drug Abuse by The Lewin Group.

A Challenge for Research

An examination of disparities in access to alcohol treatment generates more questions than answers. The most important finding is that much less than 25 percent of people in need of alcohol treatment actually get it in a given year. This analysis has used a conservative definition of treatment need that excludes most alcohol abusers due to data limitations. However, we have looked at alternative definitions of need that probably include much of the alcohol abuse

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Alcohol Disparities Among Hispanic and Non-Hispanic Whites: What Does Research Tell Us About Treatment Outcomes?

By J. Scott Tonigan, Ph.D., University of New Mexico, Albuquerque

Should alcohol treatment be tailored to ethnic and cultural needs? This question needs to be addressed seriously and answered — not only because of its implications for health care quality and access but also because of limited resources available for alcohol treatment. Two assumptions frequently come into play here: (1) that culturally sensitive treatment for special populations produces *better* outcomes relative to standard care, and, alternatively, (2) that standard care leads to *poorer* outcomes for special populations relative to members of the dominant culture.

Unfortunately, the gold standard of research to evaluate the first point — a randomized clinical trial using manual-guided and culturally sensitive therapy — has yet to be conducted. However, clinical trials have examined the relative benefit of various — albeit not culturally sensitive — treatments for different ethnic groups. This article briefly summarizes our current understanding in this area with respect to Hispanics and non-Hispanic whites.

Considerable evidence has accumulated to suggest that ethnic groups tend to present for alcohol treatment with slightly different needs and patterns of alcohol severity. Observed ethnic differences in the outpatient treatment-seeking sample in Project MATCH, for example, generally parallel findings in other studies. On average, Hispanic clients in this sample were younger than non-Hispanic white clients. They also reported having significantly less education and about the same level of alcohol dependence. Hispanics, on average, reported drinking significantly less frequently than whites during the 90-day period before treatment. But when drinking did occur, Hispanic clients drank with equal intensity as white clients.

In spite of these initial differences between ethnic groups, however, several clinical trials have found that Hispanic and non-Hispanic white clients become equally engaged in treatment, regardless of whether treatment is of an eclectic, 12-step, motivational, or cognitive behavioral orientation. Here, engagement was evaluated from a number of perspectives, including treatment compliance, satisfaction with treatment, client agreement with therapeutic goals and tasks, and therapist bonding. Likewise, a naturalistic study conducted over six months in New Mexico found no differences in outpatient therapy attendance rates between ethnic groups. It appears that while ethnic groups may present with specific manifestations of alcohol abuse and dependence, these differences do not mediate client responses to and engagement in formal outpatient treatment.

Do Hispanic clients fare as well as non-Hispanic whites *after* treatment that is not culturally sensitive? Few differences have been identified in how well different ethnic groups fare after treatment, although ethnic groups appear to select different pathways for achieving and maintaining gains made during treatment. In particular, no ethnic differences have emerged on measures of drinking intensity, total alcohol volume consumed, and percentage of abstinent days in follow-up assessments of 12 months or more. Of course, other important measures of treatment outcome — such as time to first drink and total abstinence — have yet to be considered. To accurately assess the relative benefit of non-culturally sensitive treatment for special populations, we need to take into account the full spectrum of client post-treatment functioning.

Surprisingly, research has found that even though Hispanic clients tend to report less attendance at Alcoholics Anonymous (AA) meetings than white clients, they also report roughly equal levels of engagement in AA-recommended practices, including prayer and meditation. Both groups, on average, report AA-related participation to be beneficial. The role of ethnic, cultural, and religious differences in these findings is uncertain, but it is increasingly clear that when AA meeting attendance is a primary focus of formal treatment, special attention to facilitating such participation may be warranted for Hispanic clients.

Several clinical trials have found that Hispanic and non-Hispanic white clients become equally engaged in treatment, regardless of whether treatment is of an eclectic, 12-step, motivational, or cognitive behavioral orientation.

Evidence to date does not support the assertion that formal treatment ought to be culturally sensitive in order to produce equal or better outcomes relative to standard care. However, significant pieces of evidence are still outstanding, and we should not rush to judgment. There is a pressing need to assess the relative effectiveness of culturally sensitive therapy with standard care in a randomized design for special populations. In addition, we need to broaden the measurement of treatment outcome to include such domains as quality of life and health-related functioning.

Disparities Across Treatment Settings for the Medically Indigent: Implications for Substance Abuse Screening and Interventions

By Jennifer Mertens, M.A., Constance Weisner, Dr.P.H., and Stacy Sterling, M.P.H., M.S.W.
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Research has demonstrated the effectiveness of screening and brief intervention (SBI) for alcohol problems in the primary care setting. Use of SBI in primary care can detect individuals who might otherwise go unnoticed, and it can detect problems earlier. However, new screening approaches are needed for people without health insurance or access to primary care. One alternative is the use of screening in mobile health clinics (MHCs) that provide health services to the medically indigent.

To assess the need for and effectiveness of MHC-based screening for this population, we conducted a study in an MHC setting that provides health screenings and basic outpatient medical care in Alameda County, Calif. Our findings identified serious health disparities between this group and groups from other treatment settings.

Importance of Screening

Almost 80 percent of people served by the MHC had incomes less than $10,000; only 13 percent were employed full-time. We screened a random sample of 326 MHC clients and found prevalence rates of 30 percent for hazardous drinking and 27 percent for drug problems. In comparison, a study in primary care clinics from a neighboring county found prevalence rates of 7 percent for problem drinking and 15 percent for drug problems.[1,2] Moreover, a chart review of 120 MHC clients served in the year prior to our study found a detection rate of only 13 percent for alcohol problems and 9 percent for drug problems.

Clearly, the MHC setting serves clients with a high prevalence of problems that might otherwise have remained undetected, and systematic screening may have increased detection of these problems.

Compared with a clinical/community sample of problem drinkers from a neighboring county, MHC clients with alcohol and drug problems reported strikingly high rates of psychiatric symptoms, such as depressed mood (73 percent for MHC clients versus 39 percent for comparison problem drinkers), anxiety (74 versus 54 percent), hallucinations (27 versus 8 percent), and violent behavior (26 versus 4 percent). Moreover, 44 percent of these MHC clients met DSM-IV criteria for a depressive disorder, and 37 percent met criteria for an anxiety disorder.

MHC substance-abusing clients were also likely to engage in unhealthy behaviors other than substance abuse; 83 percent reported one or more HIV-risk behaviors, and 76 percent were current smokers. In addition, one in 10 MHC substance abusers were hospitalized within six weeks of their MHC visit.

Given these high rates of co-existing problems, SBI may be more difficult and less effective in this population than among traditional primary care populations. Research is needed to identify an effective intervention for this group that is not time-intensive and does not ignore these other serious health problems.

Gender was not a predictor of psychiatric problems among MHC substance abusers. Contrary to findings in other populations, men's rates of psychiatric problems were slightly higher than were women's in this sample, and there was no gender difference in the percentage engaging in HIV-risk behaviors. However, findings on problem-related utilization were similar to other populations. Men were less likely than women to access psychiatric treatment (despite their high problem rates), but more likely to have discussed their alcohol or drug problems with medical professionals, including the MHC provider, during the six weeks after screening.

Barriers to Access

We found that almost half (49 percent) of these medically indigent substance abusers visited an ER for medical problems in the prior year, yet none reported discussing their alcohol or drug problems with ER providers. It appears that substance abuse problems remained undetected in that setting. Within six weeks after screening, only 15 percent had talked to a doctor or nurse about their problem, and the majority of those merely discussed their problem with the MHC providers in the visit conducted immediately after screening and referral.

Although we gave these clients a list of free or low-cost substance abuse treatment agencies, only 12 percent visited a substance abuse program for assessment or treatment within six weeks after screening. Reported barriers to seeking treatment included lack of funds (20 percent), transportation (15 percent), and lack of knowledge concerning available programs (8 percent). Interestingly, 36 percent did attend a 12-step meeting in the six weeks after screening — suggesting that they were more motivated to seek treatment than they were able to access *formal* treatment.

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Evidence for Alcohol-Related Health Disparities

Epidemiology has identified certain demographic groups with high levels of alcohol-related problems. A relatively robust finding from both cross-sectional and longitudinal studies during the 1990s is that African Americans and some subgroups of Hispanic individuals generally begin heavy drinking later in life and report higher rates of alcohol-related dependence and/or consequences than white non-Hispanic individuals, and that they sustain their problem drinking careers longer once developed.

These findings are confirmed by a study that pooled data between 1991 and 1993 from the National Household Survey on Drug Abuse (NHSDA). This report showed elevated risks of Alcohol Dependence for Mexican Americans in the 26-34 age bracket, with a prevalence rate of 8.4% versus 4.4% for the population overall. Rates were higher in the South and West than in other regions of the nation. Importantly, the highest rates were in non-metropolitan areas (11.5%), with some elevation among those uninsured (6.2% versus 5.5% overall in this group). In this early 1990s NHSDA study, other Hispanic subgroups (Hispanic Cubans, Puerto Ricans, and Other Hispanic subgroups) did not show these elevations, nor did non-Hispanic black subgroups.

White-Hispanic males, but not black-Hispanic males, also have extremely high rates of age-adjusted alcohol-related cirrhosis, based on National Death Index (NDI) data — rates markedly higher than black non-Hispanics (the next highest) or white non-Hispanic males. Females' rates are lower than all the male groups, with black females highest, white-Hispanic females next and black-Hispanic females near zero.

Alcohol-related cirrhosis, with an etiologic fraction of 1.0 (meaning all cases by definition are caused by alcohol) is often taken as a marker of rates of chronic alcohol dependence or alcoholism. The same type of excess alcohol-related mortality, in this case "all-cause" mortality, was seen for Mexican Americans, but not for other Hispanics or African Americans, in a recent Alcohol Research Group mortality study based on an NDI follow-up of the 1984 National Alcohol Survey (NAS). The disparities in the alcohol-related cirrhosis and all-cause mortality rates by ethnicity and gender are striking, and they fit the epidemiology of heavy drinking careers mentioned above. The disparities serve to confirm the survey-based results placing Hispanics, particularly Mexican Americans, at high risk for alcoholism and alcohol abuse.

Disparities in Treatment Utilization and Access

People with alcohol problems tend to have considerable experience with the criminal justice system, welfare departments, and other social services such as mental health agencies, health clinics, and emergency rooms. They tend to have less experience, however, with specialty substance abuse programs.

These patterns translate into different patterns of service use by men and women, and by people of different ethnic backgrounds. On a national basis, a longitudinal study based on the 1992 follow-up of the 1984 NAS found that Hispanics had more than double the involvement in Alcoholics Anonymous (AA) than whites over the eight-year period. This has been seen also in other studies, some of which have found higher AA involvement as well by African Americans. Conversely, Hispanics have not been over-represented in treatment programs other than for drinking and driving; African Americans are over-represented in public programs, other factors being equal. There is consistent evidence that more African Americans are arriving in treatment through coercion from the courts.

Such findings are fraught with confounds, especially with socioeconomic factors, and research clearly must be a renewed priority in this area. In fact, NIAAA recently identified such health services research as a clear goal. Fieldwork on the Year 2000 NAS, with large oversamples of African American and Hispanic individuals, is due to be completed in July 2001. This data set will allow us to look more closely at treatment access and health disparities in these two important minority groups.

References are available from Dr. Greenfield at tgreenfield@arg.org.

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population, and we find virtually the same patterns of differences in access across population groups.

It is critical to note that a number of factors related to economic status, lack of information, stigma, and denial impede treatment. In addition, cultural factors appear to more severely affect the willingness or ability of members of certain demographic and ethnic groups to seek treatment. Many studies find that insurance coverage for alcohol treatment is limited in comparison to that for most physical disorders. However, this analysis shows that access to treatment is materially lower among drinkers with the highest family incomes, who may be most able to pay for treatment even with no or only limited coverage. The indigent population and those with public insurance have the highest rates of access — and the public sector heavily subsidizes alcohol treatment for these populations.

Unfortunately, this kind of analysis can only scratch the surface of a complex problem. Much more must be learned about why people who need alcohol treatment do and do not get care, why they seek it where they do, and what can be done to make these points of access more effective at screening, diagnosing, referring, and treating alcohol problems.

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NIAAA Will Fund Studies on Adoption of Alcohol Research Findings in Clinical Practice

The connections between alcohol dependence and abuse research and clinicians' treatment practices are the focus of a new program announcement from NIAAA. The Institute invites applications to support studies of the adoption in clinical practice of scientific advances in the treatment of alcohol dependence and abuse.

For a complete look at this program announcement, visit http://grants.nih.gov/grants/guide/pa-files/PA-01-058.html on the Internet.

Special NIAAA Journal Volume Explores Critical Issues in Research Methodologies

NIAAA announces the availability of a supplement to the journal *Addiction*. Entitled "State-of-the-Art Methodologies in Alcohol-Related Health Services Research," the supplement comprises 10 papers that address critical issues across three major domains: methodological issues in study design and implementation; collecting valid data from community sources; and making the most of data analysis and interpretation. For free copies, call (301) 443-0786, or send e-mail to oweather@willco.niaaa.nih.gov .

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We also found that almost three in four (71 percent) of MHC substance abusers had received social services from welfare and charitable organizations in the six weeks after screening. Perhaps these are settings where substance abuse assessment and treatment services can be offered to improve access for this medically indigent population.

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